Preamble

The proposal and declaration given by the proposer and other documents if any shall form the basis of this Contract and is deemed to be incorporated herein. The two parties to this contract are the Policy Holder/Insured/Insured Persons and Care Health Insurance Ltd. (also referred as Company/ We/Us), and all the Provisions of Indian Contract Act, 1872, shall hold good in this regard. The references to the singular include references to the plural; references to the male include the references to the female; and references to any statutory enactment include subsequent changes to the same and vice versa. The sentence construction and wordings in the Add-on Policy documents should be taken in its true sense and should not be taken in a way so as to take advantage of the Company by filing a claim which deviates from the purpose of Insurance.

In return for premium paid, the Company will pay the Insured in case a valid claim is made:

In consideration of the premium paid by the Policy Holder/Insured, subject to the terms & conditions contained herein and the base policy, the Company agrees to pay/indemnify the Insured Person(s), the amount of such expenses that are reasonably and necessarily incurred up to the limits specified against respective Benefit in Add-on Policy Period.

Policy Terms & Conditions

Please check whether the details given by you about the insured persons in the proposal form (a copy of which was provided at the time of issuance of cover for the first time) are incorporated correctly in the Add on policy schedule. If you find any discrepancy, please inform us within 15 days from the date of receipt of the Add on policy, failing which the details relating to the person/s covered would be taken as correct.

So also the coverage details may also be gone through and in the absence of any communication from you within 15 days from the date of receipt of the Add on policy, it would be construed that the policy issued is correct and the claims if any arise under the policy will be dealt with based on proposal /policy details.

For the purposes of interpretation and understanding of the Add on Policy, the Company has defined, herein below some of the important words used in the Add on Policy and for the remaining language and the words the Company believes to mean the normal meaning of the English language as explained in the standard language dictionaries. The words and expressions defined in the Insurance Act, IRDA Act, regulations notified by the Insurance Regulatory and Development Authority of India ("Authority") and circulars and guidelines issued by the Authority shall carry the meanings described therein. The terms and conditions, insurance coverage and exclusions, other benefits, various procedures and conditions which have been built-in to the Add on Policy are to be construed in accordance with the applicable provisions contained in the Add on Policy.

The terms defined below have the meanings ascribed to them wherever they appear in this Add on Policy and, where appropriate.

1. Definitions

1.1 **Accidental / Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

1.2 **Age** means the completed age of the Insured Person as on his last birthday.

1.3 **Annual Multi Trip Policy** means a Policy under which there can be more than one Period of Insurance during the Policy Period, subject to the maximum trip duration (per trip) specified on the Policy Schedule/ Certificate of Insurance or as opted

1.4 **Ambulance** means a vehicle operated by a licensed/ authorized service provider and equipped for the transport and paramedical treatment of persons requiring medical attention.

1.5 **Annexure** means the document attached and marked as Annexure to this Policy.

1.6 **Assistance Service Provider** means the service provider specified in the Policy Schedule and/or Certificate of Insurance, appointed by the Company from time to time;

1.7 **Cashless Facility** means a facility extended by the insurer to the Insured where the payments, of the costs of treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the network Provider by the insurer to the extent pre-authorization is approved.

1.8 **Certificate of Insurance** means the certificate the Company issues to an Insured Person evidencing cover under the Policy;

1.9 **City of Residence** means and includes any city, town or village in which the Insured Person is currently residing in India and as specified in the Insured Person's corresponding address in the Policy Schedule/Certificate of Insurance;

1.10 **Claim** means a demand made in accordance with the terms and conditions of the Policy for payment of the specified Benefits in respect of the Insured Person.

1.11 **Claimant** means a person who possesses a relevant and valid Insurance Policy which is issued by the Company and is eligible to file a Claim in the event of a covered loss.

1.12 **Company (also referred as Insurer/We/Us)** means Care Health Insurance Limited.

1.13 **Common Carrier** means any road, rail or water conveyance or scheduled public aircraft, which is operating under a valid license from the relevant authority for the transportation of passengers and cargo for hire. If the Certificate of Insurance specifies that Personal Vehicles will also be covered, then for the purposes of that Insured Person only, Common Carrier will also include automobiles owed or used by the Insured Person.

1.14 **Condition Precedent** shall mean a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

1.15 **Congenital Anomaly** refers to a condition which is present since birth, and which is abnormal with reference to form, structure or position :

a. Internal Congenital Anomaly –
Congenital anomaly which is not in the visible and accessible parts of the body

b. External Congenital Anomaly –
Congenital anomaly which is in the visible and accessible parts of the body

1.16 **Co-payment** is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum insured.

1.17 **Country of Residence** means the country in which the Insured Person is currently residing and as specified in the Insured Person's corresponding address as specified in the Policy Schedule or Certificate of Insurance;

1.18 **Cumulative Bonus** mean any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

1.19 **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under—

a. has qualified nursing staff under its employment;
b. has qualified Medical Practitioner/s in-charge;
c. has a fully equipped operation theatre of its own, where Day Care Treatment is carried out.
d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

1.20 **Day Care Treatment** means medical treatment, and/ or Surgical Procedure which is:

a. undertaken under general or local anesthesia in a Hospital/ Day Care Centre in less than 24 consecutive hours because of technological advancement, and
b. which would have otherwise required a Hospitalization of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

1.21 **Deductible** is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

1.22 **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery .

1.23 **Disclosure to Information Norm:** The Policy shall be void and all premium paid thereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

1.24 **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

a. The condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
b. The patient takes treatment at home on account of non-availability of room in a Hospital.

1.25 **Diagnosis** means pathological conclusion drawn by a registered medical practitioner, supported by acceptable Clinical, radiological, histological, histo-pathological and laboratory evidence wherever applicable.

1.26 **Emergency Care (Emergency)** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured Person's health.

1.27 **Family** means and includes the Insured Person's legal spouse, dependent children, siblings, parents and parents–in-law;

1.28 **Geographical Scope** means the countries or geographical boundaries in which the coverage under the Policy is valid as specified in the Policy Schedule/ Certificate of Insurance;

1.29 **Grace Period** means the specified period of time immediately following the premium due date during which payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of Pre-existing Diseases. Coverage is not available for the period for which no premium is received.

1.30 **Hazardous Activities** (or Adventure sports) means any sport or activity, which is potentially dangerous to the Insured whether he is trained or not. Such sport/activity includes (but not limited to) stunt activities of any kind, adventure racing, base jumping, biathlon, big game hunting, black water rafting, BMX stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, canyoning, caving/ pot holing, cave tubing, rock climbing/ trekking/ mountaineering, cycle racing, cyclo cross, drag racing, endurance testing, hand gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, lugging, risky manual labor, marathon running, martial arts, micro – lighting, modern pentathlon, motor cycle racing, motor rallying, parachuting, paragliding/ parapenting, piloting aircraft, polo, power lifting, power boat racing, quad biking, river boarding, scuba diving, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo, ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting or wrestling of any type.

1.31 **Hijack** means any act of unlawful seizure or control of a Common Carrier with a wrongful intent using force or violence or threat thereof;

1.32 **Hospital** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

a. has qualified nursing staff under its employment round the clock;
b. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
c. has qualified Medical Practitioner(s) in charge round the clock;
d. has a fully equipped operation theatre of its own where surgical procedures are carried out;
e. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

1.33 **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

1.34 **ICU Charges** (Intensive care Unit) means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

1.35 **Indemnity/Indemnify** means compensating the Insured Person up to the extent of Expenses incurred, on occurrence of an event which results in a financial loss and is covered as the subject matter of the Insurance Cover.

1.36 **Illness** means a sickness or a disease or a pathological condition leading to the impairment of normal physiological function and requires medical treatment.

(a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery

(b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

(a) It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests;
(b) It needs ongoing or long-term control or relief of symptoms;
(c) It requires rehabilitation for the patient or for the patient to be specially trained to cope with it;
(d) It continues indefinitely;
(e) It recurs or is likely to recur.

1.37 **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

1.38 **In-patient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

1.39 **Insured Event** means an event that is covered under the Policy; and which is in accordance with the Policy Terms & Conditions.

1.40 **Insured Person (Insured)** means a self, legally married spouse, dependent children, dependent parents or any other relationship having an insurable interest and whose name specifically appears under Insured in the Policy Schedule and with respect to whom the premium has been received by the Company.

1.41 **Intensive Care Unit (ICU)** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

1.42 **Maternity expenses** shall include—

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).
b. Expenses towards lawful medical termination of pregnancy during the policy period.

1.43 **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

1.44 **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.

1.45 **Medical Practitioner** is a person who holds a valid registration from the Medical Council of any State and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

1.46 **Medically Necessary Treatment** means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

a. Is required for the medical management of the Illness or Injury suffered by the Insured Person;
b. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
c. Must have been prescribed by a Medical Practitioner;
d. Must conform to the professional standards widely accepted in international medical practice.

1.47 **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize, reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence.

1.48 **Network Provider** means Hospitals or Health Care providers enlisted by an insurer or by a Assistance Service Provider and insured together to provide services to an insured on payment by a cashless facility.

1.49 **Newborn baby** means baby born during the Policy Period and is aged up to 90 days.

1.50 **Nominee** means the person named in the Policy Schedule or as declared with the Policyholder who is nominated to receive the benefits under this Policy in accordance with the terms of the Policy, if the Insured Person is deceased.

1.51 **Notification of Claim** means the process of intimating a Claim to the Insurer or TPA through any of the recognized modes of communication.

1.52 **Non - Network Provider**: Non-Network means any hospital, day care centre or other provider that is not part of the network.

1.53 **OPD Treatment** is one in which the Insured Person visits a clinic/Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or In-patient.

1.54 **Period of Insurance** means a period within the Add-on Policy Period which commences when the Insured Person crosses the international border of the Country of Residence if the Geographical scope is out of India to leave that country on a Common Carrier or City of Residence if the Geographical Scope is restricted to India to leave that city and expires automatically on the earliest of:

a. the Insured Person crossing the Indian international border to return to the Country of Residence on a Common Carrier if the Geographical scope is out of India or returning to the City of Residence if the Geographical Scope is restricted to India; or

b. the expiry of the period specified in the Policy Schedule or Certificate of Insurance from the commencement of the Period of Insurance; or

c. the Add-on Policy Period End Date.

The Policy Schedule or Certificate of Insurance shall specify whether the Policy is a Single Trip Policy or an Annual Multi Trip Policy;

1.55 **Place of Destination** means the destination place where the journey of the Insured Person, forming part of the Trip, is scheduled to be concluded through a scheduled Common Carrier

1.56 **Place of Origin** means the starting point/ place from where the Insured Person's Trip is scheduled to be undertaken through a Common Carrier by which he finally leaves the Country of Residence or City of Residence

1.57 **Place of Residence** means the dwelling place that the Insured Person is presently resident in as specified as the correspondence address of the Insured Person in the Policy Schedule or Certificate of Insurance

1.58 **Policy** means these Policy terms and conditions and Annexures thereto, the Proposal Form, Policy Schedule and Optional Benefits which form part of the Policy and shall be read together.

1.59 **Policy Schedule** is a certificate attached to and forming part of this Policy.

1.60 **Policyholder** (also referred as You) means the person or the person who is the Group Administrator and named in the Policy Schedule as the Policyholder.

1.61 **Add-on Policy Period** means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date of the Policy as specifically appearing in the Policy Schedule.

1.62 **Add-on Policy Period End Date** means the date on which the Policy expires, as specifically appearing in the Policy Schedule.

1.63 **Add-on Policy Period Start Date** means the date on which the Policy commences, as specifically appearing in the Policy Schedule.

1.64 **Portability** means the right accorded to individual health insurance policyholders (including all members under family cover) to transfer the credit gained for pre-existing conditions and time-bound exclusions, from one insurer to another insurer.

1.65 **Post-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the Hospital provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required and
ii. The inpatient Hospitalization claim for such Hospitalization is admissible by the Company.

1.66 **Pre-existing Disease** means any condition, ailment, injury or disease

i. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or
ii. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by insurer or its reinstatement.

1.67 **Pre-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that :

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

1.68 **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness/ Injury involved.

1.69 **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

1.70 **Room Rent** means the amount charged by a Hospital towards Room & Boarding expenses and shall include the associated medical expenses.

1.71 **Subrogation** (Applicable to other than Health Policies and health sections of Travel and PA policies) means the right of the Insurer to assume the rights of the Insured Person to recover expenses paid out under the Policy that may be recovered from any other source.

1.72 **Sum Insured** means the amount specified in the Policy Schedule, for which premium is paid by the Policyholder

1.73 **Surgery/Surgical Procedure:** means manual and/or operative procedure(s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering or prolongation of life, performed in a Hospital or a Day Care Centre by a Medical Practitioner.

1.74 **Unproven/Experimental Treatment** means a treatment including drug experimental therapy which is not based on established medical practice in any state, is treatment experimental or unproven.

2. Scope Of Cover

GENERAL CONDITIONS

1. The Add-on policy can only be bought along with the Base Policy at the time of Policy Issuance and cannot be bought in isolation or as a separate product.
2. The Add-on policy is subject to the terms and conditions of this Add-on and also the Policy terms, conditions, exclusions and applicable endorsements of the Base Policy unless specifically stated under this Add-on Policy.
3. This Add-on policy shall be available only if the same is specifically mentioned in the Policy Schedule.
4. Any claim under this Add-on Policy will only be admissible when it qualifies according to the terms, conditions and exclusions in the Base Policy.
5. Coverage amount can be chosen from the applicable range in multiples of 5 only.
6. Any time period mentioned in the Deductible column represents the duration after which that respective benefit will be payable. The Policyholder can choose the time period from the range provided against the benefit.
7. Coverage under this Add-on Policy shall be on Individual basis
8. Under this Add-on Product, the Company will provide Policy Schedule to Policyholder and access of Certificate of Insurance will be provided to each Insured Member, therefore the references to the 'Policy Schedule' shall include references to the 'Certificate of Insurance'.

2.1 OPTIONAL BENEFIT 1 - TRIP DELAY

a) If the departure of a Common Carrier in which the Insured Person is scheduled to travel on a valid ticket during the Period of Insurance is delayed for more than consecutive hours as specified in the Certificate of Insurance from the later of the declared time of departure or expected time of departure due to any event beyond the control of Insured Person then the Company will pay the Coverage amount provided that the Company or the Assistance Service Provider is given written notice of the delay immediately and in any event within 30 days of the commencement of the delay and immediate alternative arrangements are made by the Insured Person for progressing the journey as scheduled.

b) **Exclusions applicable to Optional Benefit 1 – Trip Delay**

Any Claim in respect of any Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible under this Optional Benefit unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

(i) The Common Carrier is taken out of service on the instructions of the Civil Aviation Authority or any similar authority;

(ii) A Claim has already been made under either Benefit: Hijack Distress Allowance or Benefit: Missed Connection .

c) Documents to be submitted in support of the Claim:

It is a condition precedent to the Company's liability under this Optional Benefit that the following information and documentation shall be submitted to the Company or the Assistance Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Optional Benefit:

(i) Certificate from the Common Carrier confirming the delay and detailing the circumstances of delay.

2.2 Optional Benefit 2: Missed Carrier

a) The Company shall pay fixed amount specified in the Certificate of Insurance due to the Insured Person's failure to reach the original departure point of the booked journey caused by the delayed arrival due to any mode of road transport that the Insured Person is travelling in as a fare paying passenger and missed the pre-booked Common Carrier provided that:

a. The estimated time of arrival (ETA) to departure point of booked journey shall be on or before time as specified in Certificate of Insurance, before Scheduled departure time of the Common Carrier

b. The Company shall accept only one claim under this Benefit during the Add-on Policy Period and this benefit is available only within India.

b) Exclusions applicable to Optional Benefit 2: Missed Carrier

(i) Any loss which will be paid or refunded by any entity against the said event

(ii) A Claim has already been made under Benefit: Missed Connection within India

c) Documents to be submitted in support of the Claim:

It is a condition precedent to the Company's liability under this Optional Benefit that the following information and documentation shall be submitted to the Company or the Assistance Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Optional Benefit:

(i) Confirmation from the Common Carrier of the missed departure;
(ii) Copy of confirmed ticket for which Common Carrier is missed;
(iii) Valid ticket/bill that shows boarding time, ETA and actual time of arrival to departure point of booked journey

2.3 OPTIONAL BENEFIT 3 - MISSED CONNECTION

a) If the Insured Person misses the connecting flight solely and directly due to the delayed arrival of the Common Carrier in which the Insured Person was traveling on a valid ticket, the Company will indemnify the Insured Person for the cost of direct route economy class airfare actually incurred by the Insured Person to continue the journey to the scheduled Place of Destination provided that:

(i) The Company shall not be liable to make any payment under this Optional Benefit if the delay could reasonably have been foreseen by the Insured Person

or if the Insured Person could reasonably have become aware of such delay in advance;

(ii) The Company shall be liable under this Optional Benefit only if the time gap between the scheduled arrival of the Common Carrier and the connecting flight is more than consecutive hours as specified in the Certificate of Insurance;

(iii) The Company's liability to make payment under this Optional Benefit shall be in excess of the total amount refunded or returned to the Insured Person by flight service provider.

b) Exclusions applicable to Optional Benefit 3 – Missed Connection

Any Claim in respect of any Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible under this Optional Benefit unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

(i) A Claim has already been made under either Benefit: Hijack Distress Allowance or Benefit: Trip Delay.

(ii) Missing of the flight is the result of: Any deviation from the originally scheduled route at the instance of the Insured Person for any reason whatsoever;

(iii) Any advance intimation given to the Insured Person of a possible delay of the Common Carrier that might lead to missing of connecting flight;

(iv) Any circumstances other than those directly attributable to the delay of the earlier Common Carrier.

c) Documents to be submitted in support of the Claim:

It is a condition precedent to the Company's liability under this Optional Benefit that the following information and documentation shall be submitted to the Company or the Assistance Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Optional Benefit:

(i) Confirmation from the Common Carrier of the delay as to the expected time of arrival and the actual time of arrival at Place of Destination together;

(ii) Copy of unused ticket for the missed flight;

(iii) Certificate from the Common Carrier of the missed flight that the fare for the part of the journey covered by the missed flight is forfeited in full or in part together with the amount of forfeiture;

(iv) Original used ticket obtained afresh towards the alternative flight for the part of the journey covered by the missed flight indicating the amount paid as fare.

2.4 OPTIONAL BENEFIT 4 – DELAY OF CHECKED-IN BAGGAGE

a) The Company will pay the Coverage amount if the delivery of the Insured Person's Checked-In Baggage which has been entrusted to the Common Carrier is delayed by more than consecutive hours as specified in the Certificate of Insurance from the Insured Person's arrival at the Place of Destination specified on his valid ticket during the Period of Insurance.

b) Exclusions applicable to Optional Benefit 4- Delay of Checked-in Baggage:

Any Claim in respect of any Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible under this Optional Benefit unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

(i) Any delay which does not exceed the time period specified in this Optional Benefit.

(ii) Any loss for which a Claim has already been made under 'Loss of Checked in Baggage';
(iii) Any delay in delivery of the Checked-In Baggage arising out of or resulting from detention or confiscation of the baggage by the Common Carrier or customs or any government or other agencies;
(iv) Any delay attributable to damage to the Checked-In Baggage warranting an examined delivery by the Common Carrier.

c) Documents to be submitted in support of Claim:

It is a condition precedent to the Company's liability under this Optional Benefit that the following information and documentation shall be submitted to the Company or the Assistance Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Optional Benefit:

(i) Property irregularity report issued by the appropriate authority stating the scheduled time of delivery and actual time of delivery of the Checked-In Baggage;
(ii) Voucher of the Common Carrier for the delay in delivery of the Checked-In Baggage;
(iii) Copies of correspondence exchanged, if any, with the Common Carrier in connection with the delay in delivery of the Checked-In Baggage.

3. General Exclusions

This Add-on policy shall follow exclusions as mentioned in the Base policy.

4. Claims Procedure and Management

Claim Procedure and Management under this Add on Policy shall be same as the Base Policy.

5. General Terms & Conditions

5.1 Disclosure to information Norm

Conditions under this section are same as Base Policy.

5.2 Observance of Terms and Conditions

Conditions under this section are same as Base Policy.

5.3 Material Change

Conditions under this section are same as Base Policy.

5.4 Records to be maintained

Conditions under this section are same as Base Policy.

5.5 No constructive Notice

Conditions under this section are same as Base Policy.

5.6 Complete Discharge

Conditions under this section are same as Base Policy.

5.7 Policy Disputes

Conditions under this section are same as Base Policy.

5.8 Cancellation / Termination

At the request of the Policyholder, the Certificate of Insurance will be cancelled any time prior to the Period of Insurance End Date specified in the Certificate of Insurance subject to the following conditions:

(a) Full refund shall be made if the request for cancellation is received by the Company not later than 7 days from the Period of Insurance Start Date and before commencement of the first Period of Insurance if the sole reason for such cancellation is denial of visa for the countries where the Insured Person was scheduled to visit. The visa denial or cancellation letter issued by appropriate authorities shall be submitted to the Company along with the request for cancellation.

(b) Cancellation of Certificate of Insurance, issued for a Single Trip, at a date earlier than the Period of Insurance End Date specified in Certificate of Insurance can be done only if the Insured Person returns to the Country of Residence / City of Residence before the Period of Insurance End Date. Refund of premium shall only be applicable if the difference between the arrival date to the Country of Residence and the Certificate of Insurance End Date is at least 1 day. Premium refunded in case of cancellation will be as per table below.

Risk Period utilized	Premium retained
Above 50% of Add-on Policy Period	100% of Premium
Above 40% to 50% of Add-on Policy Period	80% of Premium
Above 30% to 40% of Add-on Policy Period	75% of Premium
Above 20% to 30% of Add-on Policy Period	60% of Premium
Policy inception to 20% of Add-on Policy Period	50% of Premium

(c) Cancellation of Certificate of Insurance, issued for an Annual Multi Trip , at a date earlier than the Period of Insurance End Date will be effected by the Company and the Company shall retain premium on short period scales as specified hereunder:

Period from Add-on **Policy Period Start Date**	**Total Number of Trip days utilized**	**Premium Retained**
Up to 1 month	Less than or equal to 7 days	25% annual rate
	Greater than 7 days & upto 21 days	50% annual rate
	Greater than 21 days	75% annual rate
From 2nd month Up to 3 months	Less than or upto 21 days	50% annual rate
	Greater than 21 days and upto 35 days	75% annual rate
	Greater than 35 days	Full annual rate
From 4th month Up to 6 months	Less than or upto 35 days	75% annual rate
	Greater than 35 days	Full annual rate
Exceeding 6 months	Any Trip duration	Full annual rate

(d) No refund of premium shall be eligible in case of cancellation of this Certificate of Insurance where a Claim has been incurred/ registered. The Company shall have no liability to make payment of any claims which are incurred post cancellation of the Certificate of Insurance

5.9 Limitation of liability

Conditions under this section are same as Base Policy.

5.10 Communication

Conditions under this section are same as Base Policy.

5.11 Alterations in the Add-on Policy

Conditions under this section are same as Base Policy.

5.12 Electronic Transactions

Conditions under this section are same as Base Policy.

5.13 Extension of the Add-on Policy Period

(a) Extension of the Add-on Period for a Single Trip Policy

On the Policyholder's written request, the Company may at its sole discretion after the underwriter's review extend the Add-on Policy Period provided that the total Policy Period shall not exceed the maximum trip duration (as opted by the Policyholder) specified in certificate of Insurance. If any Claim has been made under the Policy in respect of the original Add-on Policy Period:

I. The Insured shall be entitled to all benefits payable on fixed basis for which any claim has not been made with the company earlier under the same policy. For other benefits where the payment is on indemnity basis, balance coverage amount shall be available during the extended period of insurance.

(b) Extension of the Geographical Scope of the Policy

(i) On the Policyholder's written request, the Company may at its sole discretion after the underwriter's review extend Geographical Scope of the Policy specified in the Certificate of Insurance provided that the additional premium specified by the Company is received in advance of commencement of coverage and provided that the Insured Person has not already entered any part of the proposed extended Geographical Scope of the Policy or made any Claim under the Policy.

(c) All requests for extensions must be made at least 1 day before the expiry of the original Add-on Policy Period and accompanied by all the following information and documents:

(i) Duly completed application for extension;

(ii) Details of complete particulars of all Claims;

(iii) A good health declaration.

(d) However, if the request to extend the Policy is received within 3 days of the Add-on Policy Period End Date then coverage shall be reinstated, at Company's sole discretion subject to underwriting, with effect from Add-on Policy Period End Date on the date of receipt of premium by the Company. In such case Company shall not be liable for any Claim arising during the Add-on Policy Period End Date and date of receipt of premium.

(e) This product may be withdrawn by the Company after due approval from the IRDA. In case this product is withdrawn by the Company, this Policy can be extended under the then prevailing product or its nearest substitute approved by IRDA. The Company shall duly intimate the Policyholder regarding withdrawal of this product and the options available to the Policyholder at the time of extension of this policy.

(f) The Policy shall not be renewable upon expiry of the Add-on Policy Period.

5.14 Grievances

Grievance redressal procedure is same as mentioned in Base Policy.